

WISCONSIN WELL WOMAN PROGRAM
BREAST CANCER DIAGNOSTIC AND FOLLOW-UP REPORT (DRF)

Instructions: Before completing this form, refer to the Breast Cancer Diagnostic and Follow-Up Report (DRF) Completion Instructions, F-44724A. For reimbursement, send the claim and this completed form to Wisconsin Well Woman Program (WWWP), P.O. Box 6645, Madison, WI 53716-0645.

SECTION I — BILLING PROVIDER INFORMATION

1. Provider ID	2. Name — Billing Provider	3. Taxonomy Code	4. Practice Location ZIP+4 Code
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SECTION II — MEMBER PERSONAL INFORMATION

5. Last Name — Member	6. First Name — Member	7. Middle Initial — Member
8. Previous Last Name — Member	9. Member Identification Number	10. Date of Birth (MM/DD/CCYY)

SECTION III — BREAST DIAGNOSTIC PROCEDURES

ADDITIONAL MAMMOGRAPHIC VIEWS	FILM COMPARISON
11. Date Performed (MM/DD/CCYY)	21. Date Performed (MM/DD/CCYY)
12. Name — Rendering Provider (Print)	22. Name — Rendering Provider (Print)
13. RESULT (Check One Box Only) <input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign — Short-Term Follow up (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality — Consider Biopsy (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)	23. RESULT (Check One Box Only) <input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign — Short-Term Follow up (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality — Consider Biopsy (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)
BREAST CONSULTATION	FINE NEEDLE ASPIRATION
14. Date Performed (MM/DD/CCYY)	24. Date Performed (MM/DD/CCYY)
15. Name — Rendering Provider (Print)	25. Name — Rendering Provider (Print)
16. RESULT / RECOMMENDATION (Check One Box Only) <input type="checkbox"/> No Intervention, Routine Follow up <input type="checkbox"/> Short-Term Follow up <input type="checkbox"/> Biopsy / FNA Recommended	26. RESULT (Check One Box Only) <input type="checkbox"/> Not Suspicious for Cancer <input type="checkbox"/> Suspicious for Cancer <input type="checkbox"/> No Fluid or Tissue Obtained
BIOPSY	ULTRASOUND
17. Date Performed (MM/DD/CCYY)	27. Date Performed (MM/DD/CCYY)
18. Name — Rendering Provider (Print)	28. Name — Rendering Provider (Print)
19. Biopsy Associated Imaging <input type="checkbox"/> Mammogram <input type="checkbox"/> Ultrasound	29. RESULT (Check One Box Only) <input type="checkbox"/> Negative (BI-RADS 1) <input type="checkbox"/> Benign Findings (BI-RADS 2) <input type="checkbox"/> Probably Benign — Short-Term Follow up (BI-RADS 3) <input type="checkbox"/> Suspicious Abnormality — Consider Biopsy (BI-RADS 4) <input type="checkbox"/> Highly Suggestive of Malignancy (BI-RADS 5) <input type="checkbox"/> Assessment Incomplete (Findings Require Additional Evaluation) (BI-RADS 0)
20. RESULT (Check One Box Only) <input type="checkbox"/> Normal Breast Tissue <input type="checkbox"/> Other Benign Changes <input type="checkbox"/> Atypical Hyperplasia <input type="checkbox"/> Ductal Carcinoma in Situ (DCIS)* <input type="checkbox"/> Lobular Carcinoma in Situ (LCIS) <input type="checkbox"/> Invasive Breast Cancer* *Treatment Required	

Shading indicates additional follow up required for WWWP.

30. NOTES

31. RECOMMENDATION

- ☐ Follow Routine Screening Schedule _____ Months
☐ Additional Mammographic Views ☐ Ultrasound
☐ Treatment
- ☐ Short-Term Follow up _____ Months
☐ Breast Consultation ☐ Fine Needle Aspiration ☐ Biopsy

32. STATUS OF FINAL DIAGNOSIS — Check One Box Only

- ☐ Complete* ☐ Pending ☐ Member Deceased ☐ Lost to Follow up ☐ Refused Work-up

*Must complete Element 33 (Final Diagnosis).

33. FINAL DIAGNOSIS (Required if "Complete" is checked in Element 32 [Status of Final Diagnosis].)

Date (MM/DD/CCYY) if any box below is checked. _____

- ☐ Breast Cancer Not Diagnosed ☐ Lobular Carcinoma in Situ (LCIS) ☐ Ductal Carcinoma in Situ (DCIS)* ☐ Invasive Breast Cancer**

*Complete Treatment Date and Treatment Status.

**Complete Treatment Date, Treatment Status, Tumor Stage, and Tumor Size.

Continued



SECTION III — BREAST DIAGNOSTIC PROCEDURES (Continued)

34. TUMOR STAGE AND TUMOR SIZE (AJCC) — Required if invasive breast cancer.

☐ Stage I

☐ Stage II

☐ Stage III

☐ Stage IV

Tumor size _____ cm

35. TREATMENT STATUS

☐ Treatment Started

☐ Lost to Follow up

☐ Member Deceased

☐ Refused by Member

☐ Alternative Treatment (e.g., homeopathic therapy, herbal medicine, etc.)

36. TREATMENT DATE (MM/DD/CCYY)
